TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Donald G. Eaves, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-1981-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred to me by his health care provider who at the time was either an authorized network provider or had special permission outside of the network to treat the patient. It is my position that this bill should be honored as the patient was referred to me by his treating doctor for this post DDE evaluation."

Amount in Dispute: $1,100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim … is in the Texas Star Network … Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification number, and found no evidence D G EAVES DC is a participant in that Network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2016	Examination to determine MMI/IR by a referral doctor	$1,100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.1 defines the sections that are not applicable to claims subject to a workers' compensation health care network established under Insurance Code Chapter 1305.
3. Texas Insurance Code Chapter 1305 sets out the procedures for network claims.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-243 – Services not authorized by network/primary care providers.
   - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 727 – Provider not approved to treat Texas Star Network claimant.
   - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - 743 – MMI/IR has been determined by a designated doctor. Subsequent exams for MMI/IR not appropriate.

Issues

1. Are Texas Mutual Insurance Company's reasons for denial or reduction of payment supported?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

1. Donald G. Eaves, D.C. is seeking reimbursement of $1,100.00 for a "post DDE alternate evaluation at the request of the treating doctor." Texas Mutual Insurance Company (Texas Mutual) denied the disputed services with claim adjustment reason codes CAC-243 – "SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS," and 727 – "PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT."

   Review of the submitted documentation supports that the claim involved in this dispute is part of the Texas Star Network, established under Texas Insurance Code 1305. 28 Texas Administrative Code §133.1 (a) states:

   > This chapter applies to medical billing and processing for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305, and to injured employees not subject to such networks, **with the following exceptions pertaining only to health care services provided to an injured employee subject to a workers' compensation health care network established under Chapter 1305**: (1) Subchapter D of this chapter (relating to Dispute of Medical Bills) [emphasis added].

   Texas Insurance Code Section 1305.006 states, in pertinent part, "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   Texas Insurance Code Section 1305.103 requires that

   > (e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

   Dr. Eaves has the burden to prove that the appropriate approved out-of-network referral was obtained for the out-of-network healthcare he provided. Review of the submitted documentation does not support that the referral from the treating doctor was approved by the network to treat the injured employee. The division concludes that Dr. Eaves has failed to meet the requirements of Texas Insurance Code Section 1305.103. Therefore, the Texas Mutual's denial reasons are supported.

2. The division finds that the requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 2, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.